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ETHICS AND MEDICALLY ASSISTED PROCREATION:
RECONSIDERING THE PROCREATIVE RELATIONSHIP

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Abstract

This paper studies the ethical criticisms of Medically Assisted Procreation (MAP), particularly in the Francophone literature, and proposes a way of classifying them, before going on to show the limits of such criticism (the ‘medicalization’ of procreation, the upheaval in the structures of filiation, and the status of the embryo). Although this criticism is enlightening in certain cases, it is often excessive and, at the same time, overlooks the effectiveness of procreation technologies in relieving suffering of sterile couples. The author proposes three components of an axiological framework, taking into account the limits of criticism addressed toward MAP, but also the limits of MAP itself.

Since the birth of Louise Brown, the first ‘test-tube baby’ in the history of humanity, in July 1978, criticisms of medically assisted procreation (MAP) have not ceased. These criticisms are generally of two types. The first relates to the medico-technical dimension of MAP and questions the effectiveness and the safety of these biotechnologies. The second, which I will discuss here, relates to the ethical dimension of MAP.

I will initially review the ethical criticisms of MAP, particularly in the Francophone literature (although this is not significantly different in the Anglophone literature), and suggest a way of classifying them, before going on to show the limits of such a classification. These criticisms can be grouped into three categories: the medicalization of procreation, the upheaval in the structures of filiation, and the status of the embryo. We will see that, although this criticism is enlightening in certain cases, it is often excessive and, at the same time, overlooks the effectiveness of procreation technologies in relieving the suffering of sterile couples, as argued in previous work of mine¹.

The suffering of the patients is an essential element in the ethical evaluation of MAP, but it is not sufficient to construct a satisfactory axiological framework. I will show that such a framework is essential. I will propose three components of such a framework, taking into account the limits of criticism addressed at MAP, but also the limits of MAP itself.

The “medicalization” of procreation

The “medicalization” of procreation, of which some accuse MAP, is demonstrated through two professional attitudes:

1. Formulation of the desire for a child as a need to be satisfied immediately,
2. Construal of sterility as pathology.

By “formulation of the desire for a child...”, I mean a deep misunderstanding of the complexity which drives two human beings to join together and from which sometimes a child emerges as a symbol of this union. For those who denounce this misunderstanding, it is particularly limiting to imagine that the human desire for a child is only or mostly biological, while trying to resolve possible mechanical failures that may have lead to this sterility. To illustrate this, I quote Genevieve Delaisi de Parseval who wrote: “It is in the mind that children are conceived”².

Viewed as a need, the child, when it is desired, must be obtained as fast as possible and under the best possible conditions. *Desire* is formulated as a *need* everyone has the *right* to have fulfilled. In this view, sterility constitutes an obstacle to the need to have a child, which reproductive medicine has the duty to alleviate. Many authors that are critical of MAP argue that “pathologizing” sterility is likely to eliminate the psychological suffering which is sometimes the origin of this desire. It may be better to listen initially to what couples with procreative difficulties are trying to say, before launching into a series of biomedical procedures. In other words, sterility should be considered as a call to listen to the relationship rather than or only as a call to medical techniques and procedures.

Upheaval in the social structures of filiation

MAP is also regularly accused in the Francophone literature of upsetting the traditional structures of filiation, thus threatening to destroy the foundation of the human family.

Artificial insemination by sperm donor (AID) makes it possible to dissociate biological procreation and social filiation³. With this dissociation, the social father is no longer necessarily the biological father of the children carried by his partner. Socially speaking, this situation is not new. Adoption or adultery may also produce such situations. But the novelty is found in the involvement of science, specifically biotechnologies, in this dissociation.

The development of in vitro fertilization (IVF) with donor gametes (ovules and/or spermatozoa) has reinforced the difference between these two modes; biological procreation and social filiation. It has been suggested that you can make a child today by rallying different people to the cause and without anyone of them having sexual relations with anyone else⁴. You only need the collaboration of: one *genetic father*, who provides the spermatozoa, one *genetic mother* for the ovules, one *surrogate mother* providing her uterus, one *adoptive mother* who will become the socially recognized mother of the child, one *surrogate father*, companion of the surrogate mother, and one *adoptive father* who will become the legal father.

Given such dissociation of the elements of procreation, there is fear that the very basis of our life as a society will be undermined. We have an amalgam of ideas concerning paternity, situated somewhere between *bloodlines*, i.e., the parent of a child is the source of the biological conception, and the *will*—, i.e., the parent of a child is the source of the desire for, and the choice of, a child. Behind these problems, we find a question present in social anthropology: does one become a father through conception or filiation? In all human societies, as regards filiation, there may be a primacy of the social over the biological. The anthropologist Francoise Héritier states: “To sum up, there has never been a human society up to the present that is based solely on the biological sense of filiation, or that would give a

purely biological relationship the same weight as the social sense of filiation”⁵. Actually, one could advance the idea that, in the view of social anthropology, not only has the cleavage between *social filiation* and *biological filiation* existed everywhere and always, but that this cleavage makes it possible to mitigate a situation of sterility, which is often badly accepted socially.

The status of the embryo

As for the status of the embryo, there are many controversies about it. Opinion n°18 (September 16, 2002) of the Consultative Committee of Bioethics of Belgium (CCB) regarding research on human embryos *in vitro* notes the difficulty of agreeing on the moral status of the embryo. It highlights five possibilities.

The first possibility is “intentionalist” or “externalist” and is defended by those who state that the moral status of the embryo depends on the intentions of its (biological) parents. According to this approach, the human embryo cannot be regarded as a person in its own right unless it is part of a project of parenthood. Such a project is absent in the case of supernumerary embryos or embryos created for experimental purposes. The second possibility is to respect the embryo as a person as soon as the ovule has been fertilized; this position is described as “internalist” or “creationist”. A third possibility offers moral status to the embryo starting on the 15th day of development. The fourth possibility corresponds to the one defended by the National Consultative Ethics Committee for Health and Life Sciences (CCNE)⁶ in France, according to which the embryo is a potential person, i.e., it is not an actual person, but it has the potential to become one and must be respected for this potentiality. The last possibility is known as “gradualist”, in the sense that the human embryo has variable moral status according to its

degree of development: a 39 week foetus will have to be respected and protected more than a 10 weeks old embryo.

The question of the moral status of the embryo is of paramount importance, because the MAP techniques require the sacrifice of many embryos to carry out experiments. If we regard the embryo as a person from the very first stages of its development, it is clear that these experiments should cease.

Mehl writes: “In the end, scientists characterize the humanity of an embryo, not on an essential definition, but rather by what they want to do with it. Paradox: in the past, science questioned the embryo to know what it could do with it. And now, it gives the embryo a status in function of what it wants to do with it – authorize abortion, do research... So, the status of the embryo by scientists seems fundamentally opportunistic”⁷. This accusation of “opportunism” seems to structure the paper: “The Random Embryo” [L’embryon aléatoire]⁸. Her criticisms remind us of the moral principle: the end does not justify the means. Applied to our subject, this principle could mean: whatever ‘benefits’ MAP may bring to couples, it is at the unjustifiable expense of some embryos. On the other hand, those embryos may not exist from the start without MAP.

Suffering denied

Such criticisms help us recognize the weaknesses or even the dangers involved in the new MAP techniques. Nevertheless, whatever the relative merits of such criticisms, they lack insight into the suffering of sterile couples and into the effectiveness of new MAP techniques to relieve this suffering.

Many clinicians note the suffering of sterile couples that want a child. The symptoms of this distress are reminiscent of those of clinical depression. Muriel Flis-Trèves, a psychiatrist who worked in the team of Prof Frydman ('father' of the first French 'test-tube baby'), writes on this subject: "The suffering which accompanies the diagnosis [of sterility] is intense. It is often followed by a sudden withdrawal from the interests of daily existence, including work, leisure, and even temporarily from sexual activities"⁹. For men, Luc Roegiers notes that the principal elements of this depression relate to "self doubt, his sexual prowess, his capacity to transmit his genome"¹⁰.

Confronted with this suffering, MAP can bring relief to the suffering couple, quite simply by providing the long awaited child. Positive testimony from couples helped by MAP is much more difficult to find than complaints when the treatment fails. After the pregnancy has finally started, couples often forget the particular circumstances which ushered in their dearest wish. Muriel Flis-Trèves writes: "As soon as she becomes pregnant, the woman who had recourse to MAP aspires to become a mother like any other. Her pregnancy is now 'banal' and she is confronted with the same anxieties, joys and hopes as all other women"¹¹. Béatrice Koepfel, a psychologist specializing in sterility has the same position: "The first or second year after the birth of Amandine, the pregnancies with IVF [in-vitro fertilization] seemed still extraordinary. This is not at all any longer the case. On the contrary, the pregnancy is seen as banal. And it is what people appreciate with MAP: to be like any future mother, to complain about restrictions, to consult books avidly, to be no different from their peers"¹². Soon after the pregnancy is underway, even the idea of sterility becomes unbearable to many couples helped by MAP, which makes discussion of their (former) sterility very difficult.

A “blank cheque” for MAP?

If the suffering of the sterile couples constitutes an essential element of the case for MAP, it is still not reasonable to give the medical staff a “blank cheque”. It is important not to lose sight of the fact that this kind of treatment is extremely dependant on technical and scientific advances, in particular on biotechnologies. As Jacques Ellul – French sociologist who had a great influence on the Francophone philosophy of technology - states, techno scientific development is mainly guided by what we could call “technical imperatives” or “the technician’s imperative”, which can be summarized as: “Anything that is possible technically, should be done”¹³. The technology in itself is not unethical, but is in fact outside of ethics, that is to say ethically undetermined as to the question of its development.

Without ethical limits, MAP runs the risk of exacerbating the very problem it is trying to resolve: the suffering of sterile couples. We have to acknowledge the successes of MAP; we must also consider its failures and the suffering it may cause. This is suffering that the authors who criticize MAP denounce, that is to say the suffering of couples for whom MAP failed to offer the baby desired and for whom distress was increased further with the procedure. On this point, G. Delaisi de Parseval writes: “[...] medical procedures regarding infertility [...] almost always produce sexual dysfunctions: taking of temperatures, scheduled or forbidden sexual intercourse, analysis, exams, invasive treatments that interfere with sexual desire or the achievement of intercourse, anxiety induced by medicalization, [...] sometimes compromise the balanced relationship within the couple”¹⁴.

On the one hand, we must recognize the effectiveness of MAP in fighting the plague of sterility. On the other, we must avoid an approach which would justify the use of any and all

bio-technologies as regards human procreation, under the pretext of possible therapeutic benefits. It is clear, however, that such an effort at clarity can only be effective given an ethical framework, which is acceptable for both experts and patients, as well as for policy makers. Today, MAP is integrated in the medical scene and I don't intend to call into question its provision, as do numerous authors. But, while accepting the principle of MAP, it is important to optimize its provision, not only on a technical level but also on the human level.

Rethink the procreation relationship and outline a new axiological framework

It would seem worthwhile to look further at the following framework:

1. Listen to those suffering from sterility, without necessarily endorsing everything they say;
2. Respect the complexity of the gift of life;
3. Consider technical and scientific advances not as an end in themselves, but as a means to serve the couple's desire for a child (keeping resource constraints in mind).

Listen to those suffering from sterility, without necessarily endorsing everything they say

The challenge here is to encourage the parties involved in the area of reproductive medicine to take the suffering and the stress related to sterility seriously, while leaving open the question of whether or not this suffering is the cause or the consequences of this sterility. We find an illustration of this position in the words of M. Bydlowski, one of the experts on the psychology of infertility in France: "Years of work of consultation on infertility has confronted us with the suffering of patients. [...] Their distress is the consequence of their

infertility. However, it appeared to us that this suffering often exists before the symptomatic demand: the infertility would then be the testimony of that suffering”¹⁵. If the infertility is the result of mental distress, any benefit which MAP might cause may not eliminate the existential malaise; this would need to be heard and explored before or unrelated to launching a parenting project. Experts should find and use the means to differentiate among the requests for a child which they receive, to identify what are calls for help from women or couples for whom MAP is a band-aid for a wounded existence. Imagine a request for help, directed to a doctor, to have a child, from a patient who in fact desperately seeks psychological healing, a healing that may not occur even when a child might finally be born.

To illustrate this point, I turn to E. Jéronymidès, a therapist accompanying women with procreative difficulties. She relates the case of a consultation with a woman looking for medical assistance for secondary sterility. After two sessions, the patient, who had a very difficult relationship with her husband, disappeared from care for several years. The therapist later met her by chance. “Four years later, I bumped into her. She remembered me and seemed happy to speak to me. She told me that she now had a two month old little boy. She had him naturally, without MAP. She did not plan it, did not program it in any way. Then she recalled that she had not contacted the hospital or MAP programme at the time, because her father had fallen seriously ill. He had ended up being hospitalised and he died of cancer. ‘That’s the reason’, she told me, ‘that I didn’t return to see you any more. I had a lot of difficulty accepting the death’, she told me in a very serious tone, ‘I haven’t gotten over it yet and I’m not sure I ever will. It’s very difficult losing your father. I was really very attached to him’. She said that she doesn’t breast feed her child because she has a lot of work and that she has to leave her house everyday. The tone she uses about the birth of the baby is neutral, with

a hint of bitterness. It's as though the arrival of the child, and his presence with her could not, despite everything, fill the place of the loss of her father”¹⁶.

In other words, the suffering expressed at the fertility clinic can mask existential difficulties – discord within the couple, difficulties with their parents, an unhappy childhood¹⁷ – that MAP, as such, has no way of detecting or resolving, simply because MAP is a technology designed to treat biological dysfunctions. In that context, the risk is high that professionals will assist the couple with techniques they actually don't want. An interdisciplinary approach at the MAP clinic, using a team of doctors, nurses, psychologists, social workers and others can reduce this risk.

Respect the complexity of the gift of life

To give life, whether it comes “naturally” or with the assistance of medical science, does not only involve an efficient mobilization of gametes, a physiological process or a properly functioning organism. The family context, the psychological aspects and the genealogy are essential and must not be set aside. These elements are determining factors for a healthy parental relationship. Bydlowski wrote: “The human child will result from the unique mixture of the biological programming specific to the species - nucleic acids, molecules, cells – with the pre-existent parental psyche – the secret desires, dreams, memories, and words”¹⁸. Life presents a genetic or a biological dimension, but is also given to the child in the midst of lived complexity, emotional and generational relations created by their parents. MAP often undermines this complexity, as Brigitte-Fanny Cohen, a famous French journalist who engaged herself in a MAP procedure, states: “My feeling, at least, is that for [...] agents of

MAP, gynaecologists and biologists, I was just a womb and ovaries, at best, a rate of FSH, a number of follicles or oocytes”¹⁹.

In the same manner, MAP can sometimes ignore important stakeholders such as husbands or other partners and grandparents, due to the desire for a child. Husbands may not be considered as agents in their own right in the procreative project, and are sometimes treated as simple carriers of gametes. As the gynaecologist Pierre Fonty wrote provocatively: “These men have the impression of being reduced to the rank of a sperm machine that produces on demand, and to no longer being seen as beings animated by the desire for their partner, having their own desires and sexual instincts”²⁰.

However, the situation is gradually changing, as certain practitioners of MAP seem to be more aware lately of the non-biological importance of the father. Genealogical considerations are now more often invoked. Delaisi de Parseval speaks about the “father who became a father because of his own father’s regard of him; in short a father who lives through the experience of paternity that is paradoxically, not very different from that of maternity”²¹. Thus clearly “to be a father implies referring to their own role as a son”²². Paternity and fatherhood include both inheritance and transmission.

Consider technical and scientific advances not as an end in themselves, but as a means to serve the couple’s desire for a child (keeping resource constraints in mind)

Contrary to some critiques of MAP, MAP offers increasingly effective ways for sterile couples to have the desired child. But “public health education” is needed in relation to MAP. The methods and techniques of MAP need to be seen as ways of helping couples have

children and not as the cure for distress and angst in modern life. MAP does not offer happiness, but does create the technical conditions to allow the couple's happiness to be expressed through and with the birth of a child. In other words, we can't expect MAP to offer love, a sense of balance, or harmony within the couple. Quite the contrary, if the couple is fragile, the difficulties of MAP are likely to worsen the situation further. To address this, an on-going dialogue should occur between the couple and the MAP team.

Conclusion

I have argued here that criticisms of MAP ignore the fact that MAP may relieve the suffering of sterile couples. However, I have argued that this does not constitute a sufficient reason to give an ethical "blank cheque" to MAP, because MAP is a technology, and as such requires ethical discernment. Three ethical suggestions were made here: listen to those suffering from sterility, without necessarily endorsing everything they say; respect the complexity of the gift of life; and consider technical and scientific advances not as an end, but as a means to serve the couple's desire for a child (keeping resource constraints in mind). More ethical discussion of MAP is required.

¹ L. Ravez, *Les amours auscultées. Une nouvelle éthique pour l'assistance médicale à la procréation* (Paris: Cerf, 2006).

² G. Delaisi de Parseval and P. Verdier, *Enfant de personne* (Paris: Odile Jacob, 1985), 20.

³ D. Mehl, *Naître ? La controverse bioéthique* (Paris: Bayard, 1999), 45-46.

⁴ J.F. Malherbe, *Pour une éthique de la médecine* (Namur: Artel-Fides, 1997), 156.

⁵ F. Héritier, *Masculin-Féminin. La pensée de la différence* (Paris: Odile Jacob, 1996), 258.

⁶ Opinion on sampling of dead human embryonic and foetal tissue for therapeutic, diagnostic and scientific purposes (May 22, 1984) and Opinion on research and use of in-vitro human embryo for scientific and medical purposes (December 15, 1986).

⁷ Mehl, *Naître ?*, p. 90-91.

⁸ M. H. Hermitte, "L'embryon aléatoire", in *Le magasin des enfants*, ed. J. Testart (Paris: François Bourin, 1990), 238-265.

⁹ M. Flis-Trèves, *Elles veulent un enfant* (Paris: Albin Michel, 1998), 35.

¹⁰ L. Roegiers, *Les cigognes en crise* (Bruxelles: De Boeck Université, 1994), 169.

¹¹ Flis-Trèves, *Elles veulent un enfant*, p. 191.

¹² B. Koeppel, *La vie qui revient. Dans un service de fécondation in vitro* (Paris: Calmann-Lévy, 2000), 167-168.

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- ¹³ J. Ellul, *La Technique ou L'Enjeu du siècle* (Paris: Armand Colin, 1954), 122.
- ¹⁴ Delaisi de Parseval and Verdier, *Enfant de personne*, p. 61.
- ¹⁵ M. Bydlowski, *La dette de vie. Itinéraire psychanalytique de la maternité* (Paris: PUF, 2000), 119.
- ¹⁶ E. Jéronymidès, *Elles aussi deviendront mères. Des femmes qui se sentent stériles* (Paris: Payot et Rivages, 2001), 54.
- ¹⁷ Bydlowski, *La dette de vie ; Ravez, Les amours auscultées*, p. 247-336.
- ¹⁸ M. Bydlowski, *Je rêve un enfant. L'expérience intérieure de la maternité* (Paris: Odile Jacob, 2000), 24.
- ¹⁹ B. H. Cohen, *Un bébé mais pas à tout prix. Les dessous de la médecine de la reproduction* (Paris: J.-C. Lattès, 2001), 67.
- ²⁰ B. Fonty, *Les pères n'ont rien à faire dans les maternités* (Paris: Editions générales First, 2003), 100.
- ²¹ G. Delaisi de Parseval, "Les PMA ou 'Paternités médicalement assistées'", in *Le père, l'homme et le masculin en périnatalité*, ed. P. Marciano P (Ramonville Saint-Agne: Erès, 2003), 99-112, at 110.
- ²² J. Clerget, "L'homme devenant père", in *Le père, l'homme et le masculin en périnatalité*, ed. P. Marciano P (Ramonville Saint-Agne: Erès, 2003), 113-124, at 121.